MEDITECH
EXPANSE | CARE COMPASS

Keep care managers at the center of patient activity, so they can easily work in concert with patients and across care teams to coordinate the right care between visits.

With Expanse Care Compass, care managers can identify and meet the needs of your patient populations while closing care gaps. Your patients will be able to better manage their chronic conditions and maintain wellness, while your organization improves outcomes and reduces costs.

Here's how you can use Care Compass to deliver the information your care managers need to effectively guide patients:

Home Screen - Centralize care manager activities in one personalized view, making it easier to direct services and ensure effective communication among caregivers, providers, and community members across care settings.

Integration - Enable care managers to see the whole picture of each patient so they can effectively coordinate services and improve outcomes.

Patient Registries - Help care managers stay one step ahead of the needs of the chronically ill, while ensuring all patients are following the appropriate protocols to stay healthy.

Worklists - Keep everyone abreast of constantly changing patient needs, ensuring timelier responses and a lower cost of care.

Documentation -Improve care efficiencies by eliminating double-documentation and the duplication of services.

SYSTEM FLEXIBILITY

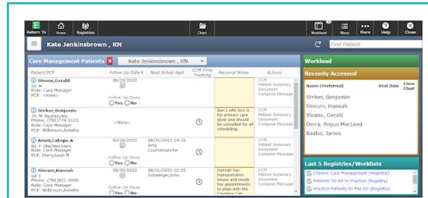
Identify which roles are associated with care management activities, whether you have a single care manager or multiple staff designated with specialized functions. Care managers may temporarily transition lists to one another to help balance workloads.

STRENGTHEN YOUR APPROACH TO POPULATION HEALTH

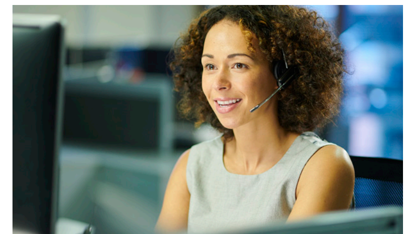
Expanse Care Compass is an effective component in an organization's already-established population health management approach and, in the U.S., it can help those working towards a value-based model of care.

FACILITATED WORKFLOW

- As the practice care manager, Kate begins her day reviewing the Chronic Care Management and Inpatient Discharged-7 Days Registries from her Expanse Care Compass home screen.
- Upon compiling the Discharged 7 Days Registry she discovers that Ben, a diabetic patient within the practice, was discharged yesterday.
- She assigns herself to his Care Team and pulls him onto her patient list to arrange a follow-up appointment.
- Because Ben is enrolled in the CCM program, she initiates CCM timing as she works through his follow-up.



- From her patient list, Kate can link directly into his chart to see the details of his recent inpatient stay.
- The patient list includes a personal note indicating his wife Ann is his health care advocate, so she knows she can discuss Ben's health with Ann when she answers the phone.
- Kate confirms with Ann that Ben's post-discharge instructions are being followed and launches into the Front Office Summary to schedule a follow-up appointment with his physician.



- Kate documents her interaction with Ben and Ann.
- She then sends a message directly to Ben's Portal confirming the details of their discussion and next steps.
- She composes a message to the primary care physician and other members of the care team to make them aware of the situation with Ben
- Kate plans to maintain a regular care management cadence with Ben to help avoid a readmission. She schedules Follow Up for 2 weeks out, when she will confirm he understands the recommendations his doctor provides at the upcoming visit.

- The counter on Kate's Care Compass Home Screen lets her know that another one of her managed patients has arrived for their follow-up appointment
- Kate can quickly confirm that she already shared pertinent information with the physician.